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THE GADFLY ROLE OF PRIVATE PSYCHIATRY

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by

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I suppose all things psychiatric on the American scene start with a dutiful tribute to Dr. Benjamin Rush, but in this instance something more than duty compels me to invoke his spirit.

During his thirty years at the Pennsylvania Hospital, Rush was essentially engaged in educating the public as to the needs of the mentally ill. Challenging the prevalent concept that the insane were insensible to the physical surroundings which they inhabited, he persuaded the Pennsylvania Legislature to vote money for a separate wing to house the mentally ill. Convinced that idleness led to deterioration, he was a leading advocate of occupational therapy.

In the early decades of the 19th century, the era of moral treatment emphasized the worth and the dignity of every individual mental patient, no matter how sick or alienated he might be. The pilot experiments in moral treatment were conducted in the private psychiatric institutions of that time -- Friends' Asylum in Pennsylvania, McLean Asylum in Massachusetts, Bloomingdale Asylum in New York, and the Hartford Retreat in Connecticut.

I mention these early bits of psychiatric history to emphasize the point that the private psychiatric hospitals, in the words and deeds of their physicians and staffs, have made an enormous contribution toward molding both the public image of psychiatry and, more importantly, toward a more compassionate image of those suffering from mental illness.

In the present century, this role of private psychiatry as both gadfly and advocate of decent, humane care for the mentally ill has moved much closer to the center of the stage in our democracy. In these endeavors, the impact of private psychiatric hospitals has far outweighed such mundane yardsticks as the percentage of private psychiatric beds in relation to the total number of psychiatric beds in this country.

For example the Menninger Clinic, a small hospital out on the windswept plains of Kansas, has played a key role in lifting levels of care for the mentally ill not only in that state, but in the entire Veterans Administration system and in many state hospital systems throughout the country. Dr. Will Menninger's appearances before more than a score of state legislatures have had an incalculable effect in nurturing a deepened public conscience leading to an increasing impatience with the dreary, custodial patterns of the past.

Dr. Francis Braceland of the Institute of Living has participated over the past decade in a unique experiment, in cooperation with "The Hartford Courant", in bringing progressive psychiatric principles to the attention of the general public. In many years of testifying before Congressional committees, Dr. Braceland has performed a notable task in giving the Congress a clearer idea of the public duty and the public responsibility with regard to the mentally ill.

Many of the psychiatric leaders at the Institute of the Pennsylvania Hospital -- Earl Bond, Edward Strecker, Lauren Smith and Kenneth Appel -- have participated actively in this broad educational process. Of particular importance is the contribution of Dr. Appel who in 1953, as President of the American Psychiatric Association, first formulated the concept of the Joint Commission on Mental Illness and Health.

Time does not permit more than a mention of additional contributions from the area of private psychiatry -- Dr. Leo Bartemeier of the Seton Institute and his work as the first Chairman of the Council on Mental Health of the American Medical Association and the Chairman of the Board of the Joint Commission; Dr. Robert Garber of the Carrier Clinic and his work with the general practitioners and with the District Assembly Branches of the American Psychiatric Association; and many more too numerous to list here.

In assessing these influences, however, one must take note of the fact that a hard line of separation between private and public psychiatry has more frequently been the rule rather than the exception.

In the 1940's as I toured both public and private institutions for the mentally ill in this country, I found that private psychiatry, as a general rule, was little concerned with the large public institutions where the great bulk of the mentally ill was confined.

Topeka in 1945 is a nice illustration of this point. The Menninger Clinic, beautifully staffed and handsomely appointed, gave the most intensive care to the few who could afford it. A short distance away, the Winter VA Hospital was in the process of developing a good quality of public psychiatric care for veterans for whom the federal government paid the bill. At the bottom of the ladder, and again only a short distance away, the Topeka State Hospital gave, at a cost of one dollar a day, the lowest level of care to patients who were wards of the state.

When the Menninger School of Psychiatry assumed the responsibility, under both state and federal allocations, for training personnel at both the Winter VA Hospital and the Topeka State Hospital, the artificial lines of separation gradually began to disappear. It was difficult to maintain rigidly distinct jurisdictional entities when you had psychiatric residents, psychological interns and other trainees rotating through all installations -- federal, state and private.

I do not mean to imply that all distinctions have been leveled -- that the average state mental institution is now, in reality, a therapeutic hospital. However, I do state categorically that the feudal baronies of the mad, run by uncertified Emperors, are fast becoming a thing of the past.

Of course, the problem of ability to pay for psychiatric care is still very much with us. The recent studies of Redlich and Hollingshead and the Cornell Surveys in New York City offer poignant evidence of the close relationship between economic status and availability of psychiatric care.

The essence of the major mental health legislation proposed by President Kennedy, and enacted by the Congress last year, is that isolation and warehousing of the mentally ill is no longer acceptable in our society. In proposing mental health centers in general hospitals and in other community locations, it dramatizes the concept that the mentally ill are to receive equal time with the physically ill.

This is a new mix and, for a while, there will be a considerable degree of insecurity as familiar walls are torn down and new services created which are tailored to the needs of the patient rather than to the availability of real estate or the power needs of an uncertified Emperor.

All will not be new -- in much that we create we can build upon the extraordinary ferment which has characterized American psychiatry for the last decade or more.

I could cite so many examples of this kind of experimentation. In Georgia, the state supports treatment in psychiatric units in general hospitals in five major cities; the important point here is that this program really began as fee-for-service support of private psychiatric treatment; this uncovered the need for beds in which local psychiatrists could hospitalize their patients.

In Delaware, and in several other states, private psychiatrists have been given staff privileges in state institutions. They can hospitalize their patients in these public hospitals, so the ancient closed staff concept goes by the boards.

In the fifteen year history of the training programs of the National Institute of Mental Health, there is illustrated a diversity which crosses all artificial jurisdictional lines.

From its inception, the NIMH has approved training programs in all types of settings -- state hospitals, university teaching hospitals, general hospitals, and private psychiatric hospitals. The emphasis has been properly placed upon the particular teaching competence of the facility, rather than upon an artificial concentration on any one type of institution as the best one for training purposes.

I must confess that in the early years of this endeavor, I had some reservations concerning the use of public funds to train professionals who subsequently went into private practice and related activities. I no longer have these reservations. Faced with tremendous shortages of psychiatric manpower, all of us can defend enthusiastically the proposition that graduates of these training programs contribute to the nation's needs wherever they serve. As several recent statistical studies of the NIMH have pointed out, the graduate trainee who restricts his activities to private practice alone is indeed a rarity. Private practitioners of psychiatry are involved in teaching,

in research, in the staffing of psychiatric units in general hospitals, and in many aspects of public psychiatry at the community level.

In recent years, the private psychiatric hospitals have assumed enormously increased responsibilities in the training of psychiatric residents and other members of the psychiatric team. Furthermore, some of the finest programs for the training of general practitioners in psychiatric skills have been conducted at these hospitals.

As we move into the new era of psychiatric enlightenment, we must weigh much more carefully the relative contributions which can be made by the diverse facilities which increasingly enrich the contemporary scene. Just as there will be an opportunity for the state institution -- strengthened and revamped -- to achieve the capability of a truly therapeutic hospital, so there will be a place for the unique contributions of the private psychiatric hospital.

I need not remind you that your greatest problem centers around the cost of private psychiatric care. However, there are many psychiatric units in general hospitals caught in the same rising spiral of high costs, so that solutions applicable to many kinds of organizations will have to be found.

Virtually the same problems loomed large a generation ago in financing the care of the physically ill. With the advent of Blue Cross and Blue Shield, increasing coverage of illness by commercial insurance companies, and health coverage benefits negotiated by labor and management, revolutionary steps were taken to reduce the dollar barrier to decent medical care.

In the next decade or two, comparable efforts must be launched in the psychiatric area. While significant progress has been made during the past decade in persuading a number of insurance carriers to cover mental illness for a limited period of time, it

is still true that there is an unjustifiable gap between those plans which provide fairly adequate coverage and those which either exclude mental illness or provide benefits ridiculously limited in scope.

The solution is not an easy one -- it will require a great deal of effort. As one who has participated over the past fifteen years at the state level in this endeavor to obtain better actuarial coverage of mental illness, I can only say to you that you must redouble your efforts to convince state officials and the public at large that discrimination by insurance carriers against mental illness is an unwarranted vestige of the past.

You have some potent allies in achieving this important objective. In November, 1962, the National Governors' Conference passed a resolution calling for the coverage of mental illness on the same basis as physical illness. In several position statements, the American Medical Association has done likewise.

The essential job is to translate these national pronouncements into a meaningful activity at the local level.

In that connection, I am impressed with recent activities here in Florida. Several months ago, I met with the attorney who is the Chairman of the Insurance Committee of the Florida Association for Mental Health. His committee includes several psychiatrists, a number of insurance executives and, quite significantly, the Deputy Insurance Commissioner of Florida. The committee has released several news letters pointing out that the general and private psychiatric hospitals in Florida each year not only treat far more patients than are admitted to the state's mental hospitals, but have an extraordinarily high batting average in preventing the majority of patients so treated from being shunted on to a state institution.

page eight

The challenge you face here is but another illustration of the point that, in the new scheme of things, your problems are shared by others.

As we build tax-supported community mental health centers throughout the country, we will run smack up against the problem of who is going to pay for their operation. In many states, the present heavy expenditures for state hospitals and clinics will make it very difficult to persuade legislators to appropriate the full amount for the operation of community centers. Since most of the patients coming to these centers will be unable to defray the costs of treatment, the solution is again in the direction of increased coverage by insurance carriers. I submit that it is in your interest to enlist in this educational process, for you cannot help but benefit by any extension of the spectrum and scope of private health insurance coverage.

To those of you who are threatened by the emergence of the tax-supported community psychiatric center -- and some of you have communicated your fears to me -- may I politely suggest that you view these fears clinically as an inappropriate response to external events? Unfortunately, there are more than enough patients; waiting lists and crowded schedules will characterize all facilities for many, many years to come.

You can, if you will, play a vital role in the incubation and hatching of these new centers. Your vast experience in developing intensive treatment services for the mentally ill in small hospitals can be of indispensable value in the planning efforts now going on in every state in the country. Your intimate and sometimes unhappy knowledge of the economic burden of psychiatric care can serve as a chastening and restraining influence upon those who would plan too much with too little.

In a very real sense, all of us face a very difficult period of trial and decision in the next few years. Change is never easy, particularly when a break is to be made



with patterns and traditions which have existed for almost two centuries. I have traveled to a number of states where the planning process is in full bloom, and I must confess that the sound and fury is sometimes discomfoting. However, out of such sound and fury at town meetings throughout the land the American Revolution was born.

That Revolution was blessed with many strong leaders who spoke out forthrightly on the issues of the day.

I appeal to you to provide similar leadership as we go about the great task of creating a revolution in the care of the mentally ill. A whole new frontier of the mind is awaiting to be explored and settled, and all of us must participate in a total commitment to this exciting venture.